Exhibit 8

UNITED STATES DISTRICT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL	)	MDL NO. 1456
INDUSTRY AVERAGE WHOLESALE	)	CIVIL ACTION
PRICE LITIGATION	)	01-CV-12257-PBS
THIS DOCUMENT RELATES TO	)	
U.S. ex rel. Ven-a-Care of	)	
of the Florida Keys, Inc.	)	
v.	)	No.06-CV-11337-PBS
ABBOTT LABORATORIES, INC.,	)	

(cross captions appear on following pages)

Deposition of HARRY LEO SULLIVAN

Volume I

Nashville, Tennessee

Tuesday, March 12, 2008

9:05 a.m.

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concerns on whether or not the payment for these kind of therapies was, was adequate?
A. Well, my opinion, particularly in the, in the home health arena, was -- and during this specific time period, the growth in Tennessee was such of those type of providers that it wouldn't -- that wouldn't -- not lead you to believe that the reimbursement for Medicaid was inadequate.
When people are hollering and screaming or you have trouble getting providers to take care of your patients is when that was more likely a concern.
Q. Well, do you know when the home infusion business really started taking off?
A. Well, it certainly took off in the early Nineties. And I can't remember -- and Tennessee was a little bit different because we very purposely avoided expansion of home community based services under the Medicaid program because the vast majority of the patients who would receive those services were dual eligibles, which meant they had Medicaid and

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Medicare. And Medicare home health was, was truly exploding. We had hundreds of providers in Tennessee of home health services. I dare say there's, you know, maybe 20 now. Because there was, there was indeed a bonanza on the Medicare side in Tennessee. Other states didn't face it quite as -- if they had chosen to expand or had very aggressive home community-based services through Medicaid, might have had a little bit different policy issues. We purely shifted to Medicare, cost shifted to Medicare, with the duals. And so it wasn't maybe not as, as intense on a Medicaid issue in Tennessee as it might be elsewhere is what I'm saying.
Q. The page starting with -- at 425 and then going over to 426, there is a discussion of what some states are doing in the home IV reimbursement area, Minnesota indicates compounding or a dispensing fee of $8 for IV drugs, and then Washington indicates that they're paying a compounding amount, Ohio as well.
Do you have an understanding of what

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they're talking about when they talk about a compounding fee?
A. Yes.
Q. And what, what is that?
A. Well, certain, be it -- I mean you can compound IV drugs if you have the right equipment and filters and hoods to keep it, make it a sterile product.
And you can compound drugs for inhalation. If you have, again, the right equipment, similar to what would be in a hospital, to, to handle sterile products.
And you take the raw ingredient and mimic whatever, generally, the brand name or the innovator product was.
Q. And do you know in Tennessee, either before TennCare or after TennCare was paying a compounding fee for IV? Do you know if that was something that was being paid?
A. Ah, no. But there's, there's ways to pay it without, without having a separate -- you know, I noticed on here that one form is for

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payment, one form is for reimbursement of supplies, one form is for -- you know, they're, they're making a variety to submit multiple forms. And I wouldn't -- I can't tell you a specific product or specific time period, but one of my strategies was in issues like this, where compounding was involved, I didn't want to go down the road, at least in the early Nineties, of getting into paying for compounded prescriptions, because that can -- that could range from a sterile product all the way down to an ointment, okay?
And, and our claims reimbursement system hadn't evolved to the current NCPDP sophistication of today. So it was very hard to put in a, a set compounding fee for what, what products?
One may take a minute to make, one may take an hour and a half.
So getting back to, to the MAC issue, some, sometimes for certain products in this arena, you would take that into account for the

MAC.
For example, I might say, I'm not paying for the tape that you use to hold the IV needle into place. I'm not paying for the IV needle or the tube set. I'm not going to -- I don't want bills for that. I know you've got to do it to administer this drug. So we're going to add on the cost of this drug X, because I know this, this and this always goes with it, and I know there is a fixed cost for that, but I don't want five bills. I want 10 different places. Bill me for the drug. And I'll make sure that the -- whatever the MAC is incorporates all your other costs. And you have to talk with providers and know what that is. I mean, you know.
Q. So, in short, you would use the payment for the drug itself to cross-subsidize other things that might need to be paid to fairly --
A. And that would include compounding.
Q. And it may include nursing services that were not included, things of that nature?
A. (Nodding yes.)

Q. Did anyone in the federal government ever tell you that you were not allowed to do that?
A. No.
Q. And if they had told you that, what would you have said?
A. That I wasn't allowed to pay for compounding or --
Q. That you weren't allowed to use the payment for the drug to cross-subsidize those other services or supplies.
A. If they had told me I couldn't do it, what would I do?
Q. Yes.
A. I would have had to have found another way to, to handle the billing.
Q. But they never told you that.
A. No.
Q. Do you know if other states were doing -- were adopting similar type strategies to run the programs?
A. No, I don't -- I mean it may be

addressed in this letter. I don't know. It seems to talk about different states, but I'm sure there were varying levels of complexity in the billing process, and what was and wasn't billable and what was and wasn't included, but I don't know it and I didn't discuss it with folks.
Q. Have you heard the term cross-subsidy or cross-subsidization in the context of pharmacy reimbursement?
A. No, not -- no, I haven't.
Q. I'm going to show you another, another -- going to mark that as another exhibit.
MR. TORBORG: I think this is 578.
(Exhibit Abbott 578 marked.)
BY MR. TORBORG:
Q. For the record, what we have marked as Exhibit 578 bears the Bates numbers HHC 002-0400 through 407. It's another Medicaid pharmacy bulletin. This one dated January-February of 1988.
Mr. Sullivan, if I could ask you to go to Bates page ending in 402. In particular the

discussion on the first full paragraph about Montana Medicaid. Do you see that?
A. Yes.
Q. Where it says, Similarly, Montana Medicaid compensates for the additional time and expense of dispensing compounded drugs by allowing the provider's usual and customary charge up to 2.5 times the cost of ingredients, paren, reimbursement for other outpatient drugs is a lower of AWP minus 10 percent, or the cost of the drug, end paren. Do you see that?
A. Yes.
Q. Is that the, the type of thing that Tennessee was doing?
A. It's a different approach to -- yeah. Make -- paying the provider for the, for the compounding without -- and setting a limit on what I will pay up to two and a half percent. It's just a different, different twist.
Q. Does it -- does this refresh your recollection about any other types of approaches like this that other states were using?